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RSC Policy Brief:
Comparative Effectiveness Research

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The RSC has prepared the following policy brief providing updates and background regarding research judging the comparative effectiveness of medical treatment options.

Background: The debate about the growth of health care costs has in recent years begun to focus on disparities in health spending and treatment. A recent Congressional Budget Office study demonstrated that regional spending on health care varies widely, yet improved care cannot be assumed by higher levels of expenditures.

Amidst rapidly growing health spending and inconsistent levels of care, policy-makers have begun to discuss the development of a research institute to study the comparative effectiveness of medical treatment programs, either by synthesizing and analyzing existing medical data or by conducting firsthand clinical trials to gauge treatments' efficacy. Advocates believe that such a center, by generating comprehensive data about the clinical and cost-effectiveness of courses of action for various diseases, could reduce health care cost growth by targeting patients with the most effective treatments and discouraging the use of costly but unproven medical techniques and methods. While many stakeholders agree that such research should be undertaken, there is less agreement on the composition and funding of the entity that would be empowered to research clinical effectiveness options.

Legislative History: Last July, the House passed—but the Senate has not considered—health legislation that included the creation of a comparative effectiveness institute. Section 904 of the Children's Health and Medicare Protection (CHAMP) Act (H.R. 3162) would create a "Center for Comparative Effectiveness Research" within the Department of Health and Human Services' Agency of Healthcare Research and Quality (AHRQ). The center would be tasked with researching "outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically."

The Center would be financed through the establishment of a Health Care Comparative Effectiveness Research Trust Fund within the U.S. Treasury. The Fund would receive transfers from the Medicare Trust Funds to finance the research program for fiscal years 2008-2010. Beginning in fiscal year 2011, funding would continue to flow from the Medicare Trust Funds, but it would be supplemented by a new tax on healthcare insurance policies. The tax would be imposed on most health insurance policies (except for workers' compensation, tort liabilities, property, credit insurance, or Medicare supplemental coverage) at a per capita amount needed to generate $375 million annually, in conjunction with resources from the Medicare Trust Funds. The Secretary of the HHS would determine the "fair share" per capita amount, but the bill's provisions are expected to generate at least $2 billion over ten years. While H.R. 3162 states that insurance carriers (or the sponsors of self-insured policies) will pay this new tax, it does not (and cannot) account for the fact that this tax will likely be passed along to consumers, raising premium costs and potentially increasing the number of Americans who cannot afford private health insurance.

H.R. 3162 would also draw down substantial funds from the Medicare Trust Funds over time, $300 million over the first three fiscal years and up to $90 million each fiscal year thereafter. Medicare Part A (hospital services) is financed by payroll taxes, and according to the nonpartisan Medicare Trustees, it is scheduled for bankruptcy in 2019—thus committing its resources for additional research will further expedite its bankruptcy. In addition, Medicare Part B (supplementary services) is financed in part from beneficiary premiums that rise as the cost of the program rises—thus tapping these funds for research amounts to a tax on every senior enrolled in Medicare Part B.

Future Outlook: Because provisions unrelated to comparative effectiveness make action on the CHAMP Act unlikely in the Senate, lawmakers and various stakeholder groups continue to engage in discussions about the way to create a research institute. Senate Finance Committee Chairman Max Baucus (D-MT) and Budget Committee Chairman Kent Conrad (D-ND) have discussed introducing stand-alone legislation on this topic; news reports indicate that their bill would fund a comparative effectiveness research institute solely from federal coffers, while House Ways and Means Health Subcommittee Chairman Pete Stark (D-CA) believes that a premium tax should help to fund the institute, so that private insurance carriers would have a financial stake in its work product.

With the current Medicare physician payment "fix" scheduled to expire June 30, and lawmakers on both sides of the aisle promising legislative action to address physician reimbursements, it is entirely possible that some form of comparative effectiveness center could be established as part of such legislation.

Implications of Comparative Effectiveness: Apart from the concerns some conservatives may have regarding any new federal taxes to finance a comparative effectiveness institute, the research undertaken by such a center could well have significant repercussions for the role of the federal government in health care. Any research undertaken would likely have an impact on the number and types of services covered by Medicare and Medicaid, as well as the treatment options and techniques utilized by physicians desiring reimbursement. Congressional Budget Office Director Peter Orszag recently admitted that "the big kick" in savings associated with comparative effectiveness research would stem from insurers—and likely the federal

government—implementing "changes in financial incentives tied to the research."[1] Although the CHAMP Act did not include provisions altering reimbursement levels to reflect comparative effectiveness research, or empowering the ostensibly non-partisan institute to do the same, such legislative measures would be a likely outcome from creation of an effectiveness center.

In addition, examples of comparative effectiveness institutes established overseas have raised concerns about whether such an approach would lead to delays in obtaining care and/or rationing of services. In the United Kingdom, Sarah Anderson, an ophthalmologist working in Britain's National Health Service (NHS), recently published an article criticizing the NHS for inhibiting access to care for her critically ill father. Her father's kidney tumor could be treated by a new drug—but while the pharmaceutical has been approved for use in Europe for two years, Britain's National Institute for Clinical Effectiveness (NICE) will not complete its assessment of the drug's usefulness until January. Until then, local NHS branches can refuse to provide the drug, leaving Anderson's family to pay for their father's treatment on their own, or face the inevitable consequences that will follow if he cannot obtain it. Anderson's ultimate verdict on her family's dilemma is a sobering one: "If Dad should lose his life to cancer, it would be devastating—but to lose his life to bureaucracy would be far, far worse."

Some conservatives may find these overseas examples of the delays resulting from a publicly-run comparative effectiveness institute a cautionary tale for those who would establish a similar institute under the aegis of the federal government. Conservatives may not only believe that such an approach would put bureaucrats, and not doctors and patients, at the center of medical policy, but would also result in the types of costly delays and care rationing that put lives at stake.

Conclusion: While the goals of a comparative effectiveness institute are certainly commendable in an era of rapidly rising health spending, some conservatives may be concerned at both the means of financing an institute and its impact on the federal role in health care. Although an institute voluntarily created and funded by private insurance or other groups could be useful, a public-private entity financed by premium taxes may only encourage lawmakers to enact additional legislative measures designed to micro-manage the doctor-patient relationship and expand an already considerable bureaucracy within the Centers for Medicare and Medicaid Services. In short, some conservatives may be concerned that comparative effectiveness research done by the public sector could become a euphemism for government-rationed health care.

If the federal government wishes to slow the growth of Medicare spending, some conservatives might find a better solution in comprehensive Medicare reform that transforms the current program into a system similar to that under the Federal Employee Health Benefits Program (FEHBP), whereby beneficiaries would receive a defined contribution from Medicare to select a health plan of their own choosing. These health plans could employ the results of comparative effectiveness research in their reimbursement policies, and consumers could use those criteria—as well as any "Consumer Reports"-type publications released by private entities—in evaluating both a health plan to purchase and treatment options for a particular medical condition.

[1] Quoted in Fawn Johnson, "Bills Pushed to Gauge Effectiveness of Medical Treatments," *CongressDaily* 17 March 2008, available online at http://nationaljournal.com/pubs/congressdaily/dj080317.htm#5 (accessed March 18, 2008).

For further information on this issue see:

- *CBO Report on Comparative Effectiveness Research*
- *London Daily Mail Article: How the National Health Service Is Letting My Father Die*

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